STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	251 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS A revisit was completed at Bristol Nursing Home on April 16, 2012, following acceptance of an Allegation of Compliance to remove the Immediate Jeopardy at F-157, F-226, F-279, F-323, F-353, F-490, and F-520, Scope and Severity level "K". The revisit revealed the corrective actions implemented April 11, 2012, removed the Immediate Jeopardy but non-compliance continues at an "E" level scope and severity for F-157, F-226, F-279, F-323, F-353, F-490, and F-520. Other deficiencies previously cited and not addressed on the Allegation of Compliance remain outstanding. The facility is required to submit a plan of correction for all outstanding deficiencies including the Immediate Jeopardy tags lowered in scope and severity.	{F 000}	F157 . 483.10(b)(11) Notify of changes The facility will notify the resident and, if known, the residents legal representative or interested family member when there is an accident involving the resident which result in injury and has the potential for requiring Physician intervention; a significant changes in the resident's physical, mental of psychological status; a need to significantly alter or change treatment or a decision to transfer or discharge the resident from the facility. 1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? • Resident # 9 A OBRA Quarterly assessment was completed on 12/13/2011 and the quarterly pain assessment was completed on 12/17/2011. The MDS coordinator updated the resident's medical record with another pain assessment on 3/29/2012.	
{F 157} SS=E	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	{F 157}	• The physician was notified of the residents' blood sugar results of 357 on 3/16/2012 and 476 on 3/23/2012 by the unit manager on 1st Tennessee on 4/09/2012. There were no new orders given. 5/11/12 • The Physician was notified by the ADON on February 14, 2012 of the recommendation to increase Buspar from 10mg every day to 7.5 TID. The ADON obtained an order for the recommended change. • Resident # 21 was placed on fifteen minute observation by the Corporate Sr. Director of clinical services on 3/30/2012 at 10:30 am. Resident #21 was transferred to Bristol Regional Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. The facility will not readmit this resident to the facility.	

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Christopher A. Goldy — Administrator — 4/26/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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(F 157)	Continued From page 1 §483.12(a).- The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to notify the physician of significant behaviors for one resident (#21); failed to notify the physician of a significant incident for one resident (#32); and failed to notify the physician of elevated blood sugars, and psychiatric recommendation for one resident (#9) of thirty-nine residents reviewed. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-157 continues at an "E" level citation (potential for more than minimal harm). The findings included:	(F 157)	• The Physician was notified of the alleged sexual abuse allegation with res. # 32 by the facility on 4/10/2012 by the Chief Executive Officer, Director of Nursing. Corporate Quality Assurance nurse and Corporate Director of Clinical services. • The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident #32 for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. • A skin assessment was completed on 1/18/2012 indicated no indication of bruising or redness any where on the resident's body. The charge nurse completed the skin assessment. 5/11/12 • Resident # 32 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. 2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? • All residents have the potential to be affected by this alleged deficient practice. • The RN supervisor completed an audit on all blood sugar flow sheets to assess for compliance with M.D. notification related to hypo/hyperglycemic on 4/10/2012.	

pg 2

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 157}	Continued From page 2 Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence the Physician was notified of the increased blood sugars, the recommendation to increase the Buspar (anxiety medication), and the possible sexual assault. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred and timely Physician notification. The facility completed mood and behavior assessments, and updated care plans related to mood and behavior. The facility provided evidence daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Interviews with the facility nursing staff revealed in-services were attended related to timely physician notification related to changes in resident conditions. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 157}	• The DON, ADON and Social Services reviewed psychiatric services progress notes for visit from 3/30/2012 to 4/3/2012 to ensure psychiatric recommendations were completed timely. All recommendations were place in the physician notification folder for the physician to review. • MD and or NP make facility visits four times a week to assess the residents and to review consultant recommendations that have been placed in the physician folder. • The Director of Nursing; Assistant Director of Nursing; Staff Development Coordinator and or the Quality Assurance Nurse provided re-education to all licensed nurses regarding Physician notification of hyperglycemic/Hypoglycemic blood sugar results and the fact that Blood sugar notification parameters are established by each Physician. • The training started on 4/10/2012 and will ended on April 11th, 2012. • All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. • The facilities do not use agency staff. • The Director of Nursing; Assistant Director of Nursing; Staff Development Coordinator and or the Quality Assurance Nurse provided re-education to all licensed nurses regarding timely notification of Psychiatric recommendations to the attending Physicians. The training was initiated on 4/10/2012 and will be completed by 4/11/2012. • All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities do not use agency staff.	

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PS 4

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{F 164} SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure privacy during an insulin injection for two residents (#13, & #34) of thirty-nine residents reviewed.	{F 164}	F 164 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** Residents #13 and #34 were assessed by the charge nurse on 4/13/2012. There were no negative outcomes noted. 2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by this deficient practice. Alert/oriented residents have been interviewed by the DON, ADON, Unit Managers and or Quality Assurance Nurse in regards to medication administration in open areas without privacy completed on 4/20/2012. No other areas of concerns were identified. 3 **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur :** In servicing of licensed staff regarding Resident Rights/Privacy/Dignity was conducted by the DON, ADON, on 4/10/2012 and 4/11/2012. In-Service of licensed staff in regards to providing privacy during medication administration will be conducted by the DON/ADON by 5/11/2012. Licensed staff will be in-serviced prior to being allowed to returning to the floor. In services will be added to the orientation packet.	5-11-12

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{F 164}	Continued From page 4 The findings included: Resident #13 was admitted to the facility on February 5, 2010, with diagnoses including Arthropathy, Diabetes Mellitus, and Chronic Kidney Disease. Observation on March 27, 2012, at 4:30 p.m., revealed resident #13 sitting in a wheelchair in the resident's room in full view of other residents and visitors. Continued observation at this time revealed Licensed Practical Nurse (LPN) # 5 obtained seven units of insulin, and without pulling the privacy curtain or closing the door, pulled up the resident's shirt exposing the abdomen and injected the insulin. Interview with LPN #5 on March 28, 2012, at 9:20 a.m., on the 200 hall, confirmed the facility had failed to ensure privacy by not closing the door or pulling privacy curtain. Resident #34 was admitted to the facility on April 14, 2011, with diagnoses including Chronic Obstructive Airway Disease, Chronic Kidney Disease, Iron Deficiency Anemia, Acute and Chronic Respiratory Failure, Diabetes Mellitus Type II, Congestive Heart Failure, Hypertension, and Hypothyroidism. Medical record review of a Physician's telephone Order dated March 24, 2012, revealed "...Novolog Insulin Inject sliding scale insulin before meals and at bedtime 51-150 = 0 units; 151-200 = 2 units; 201-250 = 3 units; 251-300 = 4 units..." Continued medical record review of the Physician's Orders dated March 1-31, 2012, revealed "...Lantus Inj (Injection) 100/ml (100	{F 164}	Starting on 4/25/2012 DON/ADON or Nurse Manager will complete three medication passes and nursing unit observations a week for four weeks and then 1 weekly x 8 weeks and then prn to ensure privacy is provided to residents. 4 **Corrective actions will be monitored to ensure the deficient practice will not reoccur** DON/ADON, Quality Assurance Nurse will report audit findings to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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{F 164}	Continued From page 5 units per milliliter) Inject 38 UNITS SUBCUTANEOUSLY EVERY EVENING..." Observation in the resident's room on March 27, 2012, at 9:15 p.m., of the medication administration of two injections of insulin to the resident's exposed abdomen, revealed the nurse did not close the curtain across the exterior window next to the resident's bed. Interview with LPN # 8 in the 1st Floor hallway, on March 27, 2012, at 9:25 p.m., confirmed the window curtain was not closed during the administration of insulin injection, exposing the resident to visitors and staff using the parking lot outside the window.	{F 164}		
{F 167} SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make the most recent complaint survey results readily accessible to residents. The findings included:	F167	1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** The complaint survey results from 11/2011 were returned to the survey book by the Chief Executive Officer on 4/9/2012. 2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** There was no negative outcome. The survey book will be maintained in the front lobby of the facility and will include the most recent annual and or complaint survey results. Signage for residents to be aware of the location of the survey book will be posted for viewing of residents	5-11-12

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{F 164}	Continued From page 5 units per milliliter) inject 38 UNITS SUBCUTANEOUSLY EVERY EVENING..." Observation in the resident's room on March 27, 2012, at 9:15 p.m., of the medication administration of two injections of insulin to the resident's exposed abdomen, revealed the nurse did not close the curtain across the exterior window next to the resident's bed. Interview with LPN # 8 in the 1st Floor hallway, on March 27, 2012, at 9:25 p.m., confirmed the window curtain was not closed during the administration of insulin injection, exposing the resident to visitors and staff using the parking lot outside the window.	~~{F 164}~~	**3 Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur:**	
{F 167} SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to make the most recent complaint survey results readily accessible to residents. The findings included:	{F 167}	The Chief Executive Officer (CEO) will check the survey result book weekly during daily rounds and will update postings immediately as they occur with the most recent annual and or complaint survey results. . **4. Corrective actions will be monitored to ensure the deficient practice will not reoccur** CEO/ Designee will report findings of the weekly checks to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved. 5-11-12	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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BRISTOL NURSING HOME	281 NORTH STREET BRISTOL, TN 37625

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{F 167}	Continued From page 6 Observation and interview on March 29, 2012, at 1:05 p.m., in the facility's lobby, revealed the state survey result book lying on a small table. Continued observation revealed the most recent complaint survey results were notincluded in the survey book. Interview at the time of observation, with the Administrator, confirmed the complaint survey results were not included in the survey result book and not accessible to the residents.	{F 167}		
{F 221} SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to re-assess for use of a restraint for two residents (#19, #8)and failed to complete a pre-restraint assessment prior to applying a restraint for two residents (#24, #6) of thirty-nine residents reviewed. The findings included: Resident # 19 was admitted to the facility on March 2, 2003, with diagnoses including Paranoid Schizophrenia, Dementia, and Anemia. Medical record review of a Physician's Order dated November 16, 2011, revealed " ...soft belt	{F 221}	F221 **1. Corrective Action(s) will be accomplishe for those resident found to been affected by the deficient practice** 5-11-12 Resident # 6 had a pre restraining assessment and an informed consent completed. Resident # 19 soft belt restraints was discontinued on March 22nd, 2012. Resident #8 – the side rails were removed on 3/30/2012 and his bed was replaced with a new bed that has assist rails. A side rail assessment was completed was completed on 3/31/2012. Care plan was updated on 3/31/2012. Resident #24 – a pre restraint assessment and a restraint assessment was completed on 4/13/2012 by the unit manager.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(F 221)	Continued From page 7 when up in wc (wheelchair)... "Continued medical record review of a Physician's Order dated March 22, 2012, revealed "...d/c (discontinue) soft belt..." Interview and medical record review with the Director of Nursing (DON), in the Bookkeeper's office, on March 29, 2012, at 2:15 p.m., confirmed the facility had failed to complete a quarterly re-assessment for the use of a restraint for resident #19. Resident #8 was re-admitted to the facility on February 16, 2012, with diagnoses including Left Hip Fracture, Diabetes Mellitus Type II, and Dementia. Medical record review of the Minimum Data Set (MDS) dated March 8, 2012, revealed the resident was unable to complete the Brief Interview for Mental Status (BIMS), had long and short term memory problems, had moderately impaired cognition, and was totally dependent on all staff for activities of daily living. Medical record review of the Evaluation For Use of Side Rails dated November 23, 2009, and last reviewed on October 28, 2011, revealed "... Recommended Type...Full side rail...Left..." Observation of the resident on March 27, 2012, at 3:06 p.m., and 8:00 p.m., revealed the resident lying in bed with bilateral full side rails up. Interview with Certified Nurse Aide (CNA) #2 on March 28, 2012, at 11:52 a.m., at 2nd TN (Tennessee) nursing station, and with CNA #3 on March 28, 2012, at 12:08 p.m., in 2nd TN hallway, confirmed the resident was capable of moving and exiting the bed, and staff always put	(F 221)	2 **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected. 100 % record review by Nursing Administration of side rail assessments/physical restraints used was completed on 4/16/2012 to ensure all assessments are current and accurate with care plans updated. 3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur:** In-service of licensed staff regarding side rail assessments/pre-restraint assessment forms/restraint reduction forms/and informed consent forms will be complete by 5/11/2012. Licensed staff will be in serviced prior to being allowed to work on the floor. In services will be added to the orientation packet. Care guides will be update when a side rail assessment or physical restraint assessment is completed or updated. Starting on April 23rd the DON/ADON or unit managers will audit 5 charts/week x 4 weeks then 2 charts/week x 4 weeks then randomly to ensure the assessments are completed upon timely.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 221}	Continued From page 8 both full side rails up "for safety." Interview with MDS Coordinator #1 on March 29, 2012, at 2:00 p.m., in the MDS office, confirmed the MDS Coordinator was unaware the resident had been placed in a bed with full bilateral side rails in use; confirmed bilateral full side rails would be a restraint for the resident; and confirmed the resident had not been assessed for restraints. Resident #24 was admitted to the facility on June 23, 1999, with diagnoses including Psychosis, Dementia, and Anxiety. Observation on March 28, 2012, at 8:40 a.m., in the facility dining room revealed resident #24 sitting at a table drinking coffee with a self release belt attached to the wheelchair. Medical record review of a Physician's Order dated March 2, 2012, revealed "...self release belt... "Continued medical record review revealed no documentation of a pre-restraint evaluation prior to placing the self release belt. Interview and medical record review with the Director of Nursing (DON), in the Bookkeeper's office, on March 29, 2012, at 2:15 p.m., confirmed the facility failed to complete a Pre-Restraint Assessment prior to placing a restraint for resident #24. Resident #6 was admitted to the facility August 5, 2009, with diagnoses including Mental Disorder, Dementia with Behaviors, Anxiety, Osteoporosis, and History of Fall.	{F 221}	Starting on April 23rd the DON/ADON or Nurse Manager will review new admission/readmissions for completion and accuracy of assessments in the daily clinical meeting Monday through Friday. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur** DON/designee will report findings of audits to the Quality Assurance Committee monthly.. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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(F 221)	Continued From page 9 Medical record review of the Minimum Data Set dated January 8, 2012, revealed the resident had impaired short and long term memory, had moderately impaired cognitive skills for daily decision making, had wandering behavior that occurred daily, and required extensive or total assistance for all activities of daily living. Medical record review of the Care Plan dated August 4, 2011, and updated through April 12, 2012, revealed "...personal alarm while in bed, a self release alarming seat belt while in the wheel chair, a positioning vest when in the wheel chair, and full bed rails while in bed for mobility..." Medical record review of the Pre-Restraining Evaluation dated February 27, 2012, revealed "...Velcro positioning vest while up in WC (wheelchair) for positioning and safety r/t (related to) poor safety awareness r/t Dementia a (and) poor trunk control..." Medical record review of a Physician Telephone Order dated March 13, 2012, revealed "...D/C (Discontinue) Posey Vest...Front anti-tippers...Alarming Self Release Belt..." Observation and interview with the Director of Nursing (DON) in the day room on 2nd Tennessee, on March 27, 2012, at 2:00 p.m., confirmed the resident was unable to release the seat belt and no positioning vest was in place. Interview with LPN # 6 on March 28, 2012, at 3:45 p.m., in the 2nd Tennessee hall, confirmed a Pre-Restraining Assessment and an Informed Consent for Use of Restraints had not been	(F 221)		

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{F 221}	Continued From page 10 completed when the self-release belt was ordered March 13, 2012.	{F 221}		
{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed identify and investigate possible abuse perpetrated by one resident (#21) or incidents with four residents (#17, #32, #36, and #38). The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-226 continues at an "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence the Physician was	{F 226}	F 226 483.13 (c) Develop / Implement Abuse/Neglect, ETC Policies The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? • . Resident # 21 was transferred to another facility on 3/30/2012. The Facility will not readmit this resident. • The social worker completed a PHQ9 assessment on res. # 17 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. • A skin assessment was completed on 1/20/2012 by a charge nurse which indicated a right hip wound was present however there was no indication of bruising or redness anywhere on the resident's body. Skin assessments dated 3/18/2012, 3/22/2012 and 3/26/2012 was completed by a charge nurse. No new skin issues were identified.	5-11-12

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• The care plan for res. # 17 was updated by social services, MDS Coordinator and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan. • The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012. • Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am. By the Corporate Sr. Director of Clinical Services. • Resident #21 was transferred to Bristol Regional Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. This resident will not be readmitted to the facility. • The nurses note for Resident #32 dated 1/13/2012 at 10:00 am states the resident is on antibiotics for a UTI. Resident gestures with c/o generalized discomfort, the MD gave a new order for Lortab. The resident's son was made aware as he was visiting at the time. • The nurses' note dated 1/14/2012 states the resident "having questionable bleeding from rectal area. MD notified with new orders to send resident to ER for evaluation and treatment. RP was notified of residents' status and aware of resident going to the ER." Nurse's note dated 1/14/2012 at 6:00pm states the resident was admitted to BRMC with a diagnosis of Pneumonia. The hospital was not notified of the possible sexual assault.	5-1-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• The social worker completed a PHQ9 assessment resident # 32 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. • A skin assessment was completed on res. # 32 on 1/18/2012. There was no indication of bruising or redness any where on the resident's body. The charge nurse completed the skin assessment. • Resident # 32 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan. • The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012. • It was reported that on 1/19/2012 resident #21 was observed lying in this Resident's bed with his pants off, his underwear was on. Resident #36 was fully clothed. Resident # 21 was transferred to another facility on 3/30/2012.	5-11-12

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• The social worker completed a PHQ9 assessment on resident # 36 on 3/31/2012 to assess this resident for signs and symptom of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. During the assessment this resident stated that this is not a good time for her, she is having problems with her daughter and at times she has thoughts that she would be better off dead. The resident stated no when the social worker asked her if she had a plan to harm herself. The social worker notified the nurse. The nurse obtained an order for a Psychiatric evaluation. • The nursing staff observed the resident # 36 through out the night and completing thirty minutes observations until the resident was evaluated by psychiatric services. • The M.D was notified and agreed to the recommendations for Medication changes and the discontinuation of the frequent checks by the unit manager on 2nd Tennessee. • A skin assessment was completed on resident # 36 on 3/18/2012, 3/30/2012 which revealed no bruising or redness. The skin assessment was completed by the charge nurse. • Resident # 36 care plan was updated with refer to psych services, monitor every 15 to 30 minutes until seen by Psych services. Social Worker, MDS Coordinator, the Quality Assurance Nurse and Sr. Director of clinical services updated the care plan on 03/31/2012. The Corporate Sr. Director of Clinical Services and the Corporate Quality Assurance nurse immediately notified the nursing staff of the changes in the care plan.	5-11-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• The M.D was notified and agreed with recommendations from psychiatric services for Medication changes and the discontinuation of the frequent checks on 4/3/2012. • Care plan was updated with D/C frequent checks on 4/3/2012 by the unit manager. The Director of nursing updated the resident care guides to ensure the nursing assistants were aware of the changes to the plan of care on 4/11/2012. • Resident # 38 states she was awakened early in the morning on 3/30/2012 with Resident # 21 standing over her bed. He scared her and she slapped his arm. Resident # 38 stated "I don't like it." • Resident # 21 was placed on fifteen minute observations until he was discharged another facility at 4:00 pm on 3/30/2012. • The social worker completed a PHQ9 assessment on resident # 38 on 4/9/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. This assessment was documented in the social services note. • A skin assessment was completed on res. # 38 on. 3/30/2012. The skin assessment revealed that the resident had bruising from blood draws and around her Dialysis Shunt. The skin assessment was completed by the charge nurse.	5-11-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• Resident # 38 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan. • The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012. 2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? All residents on 2nd Tennessee may be affected by the same alleged deficient practice. • As part of the initial assessment, the nursing staff will identify individuals with a history of impaired cognition, problematic behaviors, or mental illness. • The charge nurses will notify the physician of residents with problematic behaviors and will obtain an order for a psychiatric referral for medication and or behavior management as needed. • On 3/30/2012 Staffing was increased by 43% (4- staff members resulting in a ratio of I C.N.A. to 7 residents on the 7A-7P shift and increased by 25% 2 staff members resulting in a ratio on 1 C.N.A. to 8 residents on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing levels.	5-11-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• To increase and retain the increased number of staff on 2nd Tennessee the facility has Placed a newspaper ad locally, on Craig's list and, on Monster.com for C.N.A's, LPN's and RN's. • Offering a $500.00 new hire sign on Bonus for LPN's and C.N.A.'s. • Offering a $250.00 referral Bonus to current employee that refers other nursing staff that are hired and stay past ninety days. • A perfect attendance Bonus of an additional twenty-five cent per hour worked per pay period has been implemented for nursing assistants. • *What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur* • To ensure the facility staff understand how to properly manage residents with behaviors, how to report, investigate and implement interventions after a behavioral event. All staff will receive education on: • Managing residents with Dementia and Dementia related behaviors. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. • Implementation of interventions to prevent a behavior. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012. • Implementation of interventions after a behavioral event has occurred. Contracted Hospice provider is scheduled to provide the above training. The training began on 4/5/2012 and will be completed by April 11, 2012.	5-11-12

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{F 226}	Continued From page 11 notified of alleged sexual assault. The facility completed skin assessments on 100% of the residents on 2nd Tennessee. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reveiwed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions for all residents. The facility completed mood and behavior assessments, and updated careplans related to mood and behavior. The facility provided evidence of daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for	{F 226}	• The Corporate Sr. Director of clinical Services, corporate Quality Assurance Nurse and or Director of Nursing will re-educated all staff on the types of abuse, the policy and procedure for reporting and investigating abuse, Sexual behaviors and possible sexual abuse. The training began on 4/4/2012 and will end on 4/11/2012. • All staff who missed the in-service will be in-serviced by the staffing coordinator and or the corporate Quality assurance nurse prior to being allowed to work the floor. The facilities do not use agency staff. • *How the corrective actions will be monitored to ensure that the deficient practice will not recur; what quality assurance program will be put In place* • The charge nurses will utilize the Psychoactive Medication monthly flow record and or the nurses' notes to document resident changes in mood and or behaviors. • Starting the week of April 23rd the Unit managers will review the psychoactive medication monthly flow records daily to ensure the record correctly reflects the resident behaviors for the day. The flow records will be audited Monday through Friday for four weeks and then weekly for two weeks and then PRN. • Unit mangers will give a copy of each audit to the Director of Nursing or the Assistant Director of Nursing during the clinical meeting Monday through Friday. • The Director of Nursing (DON) or the Assistant Director of Nursing will maintain the audits in the survey readiness binder in the DON office. • Starting the week of April 23rd the Director of Nursing (DON) or the Assistant Director of Nursing will review the monthly flow records on 2nd Tennessee weekly for four weeks to ensure resident behaviors are properly documented.	5-11-12

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{F 226}	Continued From page 12 the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing Assistants to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistant to eight residents) for 7P-7A shift. Staffing will be increased to six Nursing Assistants on the 7A-7P shift and five Nursing Assistants on the 7P-7A shift. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 226}	• The DON/ ADON and or Quality Assurance Nurse will audit 100% of the abuse investigations to ensure the allegation was properly investigated and reported to the appropriate state agency. • Starting April 23rd Abuse Audits will be completed weekly for eight weeks and then biweekly for eight weeks and then monthly. Starting on the week of April 23rd the Administrator, DON\ADON or Nurse manager will make observations on 2nd Tennessee at least daily Monday thru Friday to ensure staff is monitoring resident behaviors and responding appropriately. *4. How the corrective actions will be monitored to ensure that the deficient practice will not recur; what quality assurance program will be put In place* • The DON/ADON will report audit findings to the interdisciplinary team (Administrator, Director of Nursing, Assistant Director of Nursing, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, Therapy Manager) in the monthly Quality Assurance Committee meeting until system compliance is achieved.	
{F 246} SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide adequate equipment to meet the needs of one resident (#4) of thirty-nine residents	{F 246}	F246 1. Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice: Resident # 4 was repositioned by the charge nurse. The bedside table was replaced with a table that will extend across the bed. The nursing assistant assigned to this resident re-educated by the unit manager on 3/27/2012 on properly positioning resident in bed during meal time.	

5/11-12

Pg 23

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{F 246}	Continued From page 13 reviewed. The findings included: Resident #4 was admitted to the facility on September 2, 2011, with diagnoses including Dementia, Congestive Heart Failure, and Pericardial Disease. Medical record review of the Minimum Data Set dated March 12, 2012, revealed the resident required moderate assistance with decision making, had short and long term memory problems, and required extensive assistance with all activities of daily living. Observation on March 27, 2012, at 7:38 a.m., revealed the resident lying in bed on the right side, in the resident's room, eating breakfast. Observation revealed the breakfast tray was on a bedside table raised to the height even with the top of the mattress. Continued observation revealed the resident dropping food in the bed. Interview with a Licensed Practical Nurse (#6) on March 27, 2012, at 7:50 a.m., in the resident's room, confirmed the bedside table was not designed to extend across the resident's bed and it was not adequate to meet the needs of the resident..	{F 246}	**2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected. Residents identified as eating in bed where checked and repositioned as needed. **3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Starting the week of April 23rd the Unit managers and or Charge nurses will monitor positioning of residents at meal times for two meal per day for two weeks then one meal daily for two weeks and PRN. Starting on April 26th the staff will receiv re-education on proper positioning of residents during meals by 5/11/2012. The DON, ADON, Staff Developer and or Quality Assurance Nurse will provide the education. Staff will be in serviced prior to being allowed to return to the floor. In services will be added to the orientation packet.	5/11/12
{F 248} SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	{F 248}		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 246}	Continued From page 13 reviewed. The findings included: Resident #4 was admitted to the facility on September 2, 2011, with diagnoses including Dementia, Congestive Heart Failure, and Pericardial Disease. Medical record review of the Minimum Data Set dated March 12, 2012, revealed the resident required moderate assistance with decision making, had short and long term memory problems, and required extensive assistance with all activities of daily living. Observation on March 27, 2012, at 7:38 a.m., revealed the resident lying in bed on the right side, in the resident's room, eating breakfast. Observation revealed the breakfast tray was on a bedside table raised to the height even with the top of the mattress. Continued observation revealed the resident dropping food in the bed. Interview with a Licensed Practical Nurse (#6) on March 27, 2012, at 7:50 a.m., in the resident's room, confirmed the bedside table was not designed to extend across the resident's bed and it was not adequate to meet the needs of the resident..	{F 246}	4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur :** DON/designee will report findings of audits to the Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-1-12
{F 248} SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	{F 248}		

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{F 246}	Continued From page 13 reviewed. The findings included: Resident #4 was admitted to the facility on September 2, 2011, with diagnoses including Dementia, Congestive Heart Failure, and Pericardial Disease. Medical record review of the Minimum Data Set dated March 12, 2012, revealed the resident required moderate assistance with decision making, had short and long term memory problems, and required extensive assistance with all activities of daily living. Observation on March 27, 2012, at 7:38 a.m., revealed the resident lying in bed on the right side, in the resident's room, eating breakfast. Observation revealed the breakfast tray was on a bedside table raised to the height even with the top of the mattress. Continued observation revealed the resident dropping food in the bed. Interview with a Licensed Practical Nurse (#6) on March 27, 2012, at 7:50 a.m., in the resident's room, confirmed the bedside table was not designed to extend across the resident's bed and it was not adequate to meet the needs of the resident..	{F 246}	F248 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice:** Resident # 17 was covered with a towel and taken to the shower room and redressed by the charge nurse on 3/27/2012 Resident # 17 was placed on fifteen minute observations by the charge nurse from 7:15 am to 7:00 pm. 2. **Identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** Residents on 2nd Tennessee were identified by the MDS response to section E for wandering and behaviors. Care plans were updated. Residents are assessed upon admission, quarterly, and with significant changes to identify behaviors to include wandering.	5-11-12
{F 248} SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	{F 248}		

Pg 2d

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{F 248}	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to meet the needs of one resident (#17) of thirty-nine residents reviewed. The findings included: Resident #17 was admitted to the facility on October 28, 2011, with diagnoses including Intracranial Injury, Facial Fractures, Dementia, Abnormality of Gait, Muscle Weakness, Failure to Thrive, and Senile Cachexia. Medical record review of the Minimum Data Set (MDS) dated January 22, 2012, revealed the resident required extensive assistance with decision making, had short and long term memory loss, and was totally dependent for activities of daily living. Observations on March 26, 2012, at 2:52 p.m., 3:00 p.m., 4:18 p.m., and 4:23 p.m., March 28, 2012, at 2:15 p.m., and March 29, 2012, at 8:00 a.m., 8:38 a.m., and 1:44 p.m., revealed the resident was constantly wandering in an out of other resident's rooms without redirection or being engaged in any activity by staff. Observation on March 26, 2012, at 3:01 p.m. to 3:06 p.m., revealed the resident was in another resident's room with the door shut. Continued observation revealed the resident was sitting in a wheelchair with the bottom drawer of the bedside table belonging to the resident in B bed opened.	{F 248}	**3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Nursing staff received education on managing residents with behaviors to include wandering on 4/11/2012. The education was provided by the corporate hospice provider and or the Assistant Director of Nursing. Nursing staff will be in serviced prior to being allowed to work the floor. In services will be added to the orientation packet. Starting week of April 23rd Charge nurses will document resident behaviors on the psychoactive medication monthly flow record and or in the nurses' notes. Starting week of April 23rd Unit manager will audit the psychoactive medication monthly flow record daily Monday through Friday for two weeks and then weekly for two weeks. Unit managers will report audit findings in the daily clinical meeting Monday through Friday. Audit tools will be maintained in the DON's office.	5-1-12

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{F 248}	Continued From page 17 confirmed "folding towels is an activity that keeps the resident's attention the longest" and when residents go into other residents rooms "staff bring them to day room for re-direction." Further interview on March 29, 2012, at 3:01 p.m., in the first floor conference room, confirmed there was two planned activities per day on the second floor and staff had not been instructed on doing activities with residents. Further interview confirmed there were three activity personnel for the facility with plans to hire additional activity staff for the second floor. Further interview confirmed "when (residents) engaged in activities they are more settled and calm and it is very challenging to meet the needs of the differing residents." Further interview with the Activity Director confirmed there was opportunity for improvement on the second floor. Interview with LPN #6 on March 29, 2012, at 1:37p.m., at the 2nd Tennessee floor nurses station, confirmed "as long as we have activities, supervision isn't a problem."	{F 248}	Starting the week of April 23rd for 4 weeks the Administrator, DON\ADON o Nurse manager will make observations o 2nd Tennessee at least daily Monday thru Friday to ensure staff are providing divisional activities and increased resider activities. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur :** DON/designee will report findings of audits to the Quality Assurance Committee monthly until compliance is achieved. The Quality Assurance Committee will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-14-12
{F 256} SS=F	483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observation group interview and individual interviews the facility failed to provide adequate lighting for the needs of residents and staff. The findings included:	{F 256}	F 256 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** New light fixtures were added to the hallway increasing illumination. Resident rooms had light bulbs changed to fluoresces bulbs to increase illumination.	

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(F 256)	Continued From page 18 Interview conducted the with resident group on March 27, 2012, at 11:05 a.m., in the staff lounge, revealed seven out of seven residents residing on the 100 and 200 hall had the following complaint's: "...need more lighting...lighting is awful...podiatrist has difficulty seeing..." Observation during medication administration on March 27, 2012, at 5:30 p.m., on the 100 short hall, revealed the hallway to have very dim lightning. Continued observation revealed the Licensed Practical Nurse (LPN) #3 squinting the eye to draw up insulin for a resident. Interview with LPN #3 on March 27, 2012, at 5:40 p.m., on the 100 short hall, confirmed the lightning was not adequate to do resident care. Interview with the facility Maintenance Director on March 29, 2012, at 8:30 a.m., on the 200 short hall, confirmed they were always receiving complaints about the lighting. "...wall lighting needs replaced...always nurse's and resident's complaining..."	(F 256)	2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents and staff have the potential to be affected by this alleged deficient practice. 3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Lighting fixtures in resident rooms' and hall ways will be checked by maintenance to ensure proper and increased lumination is in place. The Chief Executive Officer (CEO) and or Activity Director starting on April 25, 2012 will discuss lighting levels in the resident council meeting monthly until th resident's state that they are satisfied with the lighting levels. Starting on April 25, 2012 the CEO will interview three to five staff members an residents weekly for four weeks and the PRN to ensure the residents and staff are satisfied with the lighting levels.	5-17-12
(F 272) SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	~~(F 272)~~		

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	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 256}	Continued From page 18 Interview conducted the with resident group on March 27, 2012, at 11:05 a.m., in the staff lounge, revealed seven out of seven residents residing on the 100 and 200 hall had the following complaint's: "...need more lighting...lighting is awful...podiatrist has difficulty seeing..." Observation during medication administration on March 27, 2012, at 5:30 p.m., on the 100 short hall, revealed the hallway to have very dim lightning. Continued observation revealed the Licensed Practical Nurse (LPN) #3 squinting the eye to draw up Insulin for a resident. Interview with LPN #3 on March 27, 2012, at 5:40 p.m., on the 100 short hall, confirmed the lightning was not adequate to do resident care. Interview with the facility Maintenance Director on March 29, 2012, at 8:30 a.m., on the 200 short hall, confirmed they were always receiving complaints about the lighting. "...wall lighting needs replaced...always nurse's and resident's complaining..."	{F 256}	4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur:** The Chief Executive Officer will report the findings of the interviews to the Quality Assurance Committee. The Quality Assurance Committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	
{F 272} SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:	{F 272}	F 272 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** Quarterly pain assessment was completed for resident # 3 on 3/27/2012 and the pain assessment for resident #9 was completed on 3/29/2012.	5-17-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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{F 272}	Continued From page 19 Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to complete quarterly pain evaluations for two residents (#3, #9) of thrity-nine residnets reviewed. Resident #3 was admitted to the facility on April 22, 2011, with diagnoses including Mental Disorder, Glaucoma, and Late Stage Dementia.	{F 272}	**2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same deficient practice. The DON, ADON, Nurse manager and or Quality Assurance Nurse will complete a Chart review on 100% of the resident records by 5/11/2012 to ensure a quarterly pain assessment has been completed. **3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Starting on April 25th the Nurse managers and or Quality Assurance Nurse will audit five charts weekly for four week to ensure quarterly pain assessment have been completed. Nurse managers will report the result of audits to the DON.	5-11-12

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PRINTED: 04/10/2012
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OMB NO. 0938-0391

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BRISTOL NURSING HOME	251 NORTH STREET BRISTOL, TN 37625

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{F 272}	Continued From page 20 Medical record review of a facility Pain Evaluation revealed the most recent completed evaluation was November 18, 2011. Continued review of the Pain Evaluation revealed it was to be completed quarterly. Interview and medical record review with Minimum Data Set (MDS) coordinator #1 and #2, in the MDS office, on March 29, 2012, at 9:20 a.m., confirmed the Pain Evaluation was not completed quarterly. Resident #9 was admitted to the facility on January 30, 2003, with diagnoses including Altered Mental Status, Acute Renal Failure, and Diabetes Mellitus. Medical record review of a facility Pain Evaluation revealed the most recent completed evaluation was December 17, 2011. Continued review of the Pain Evaluation revealed it was to be completed quarterly. Interview and medical record review with Minimum Data Set (MDS) coordinator #1 and #2, in the MDS office, on March 29, 2012, at 9:20 a.m., confirmed the Pain Evaluation was not completed quarterly.	{F 272}	4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur:** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12
{F 273} SS=D	483.20(b)(2)(i) COMPREHENSIVE ASSESSMENT 14 DAYS AFTER ADMIT A facility must conduct a comprehensive assessment of a resident within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of	{F 273}	F 273 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** A comprehensive assessment was updated with care plan reviewed and updated as needed on resident # 5 on 3/26/2012 by the MDS coordinator	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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{F 273}	Continued From page 21 this section, "readmission" means a return to the facility following a temporary absence for hospitalization or for therapeutic leave.) This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to complete a comprehensive assessment within fourteen days after admission for one resident (#5) of thirty-nine residents reviewed. Resident #5 was admitted to the facility on February 20, 2012, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and Generalized Anxiety. Medical record review of an Initial Care Plan dated February 20, 2012, revealed "...to be initiated on admit and used for up to 14 days..." Interview and medical record review with the Minimum Data Set (MDS) coordinators #1 and #2, on March 26, 2012, at 2:31 p.m., in the MDS office, confirmed the facility failed to complete a comprehensive assessment within fourteen days after admission.	{F 273}	2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents admitted to the facility have the potential to be affected by this alleged deficient practice. A chart review will be completed fourteen to twenty days after the date of admission by the DON, ADON, MDS Coordinator, and or Corporate Quality Assurance Nurse to ensure a comprehensive ~~care plan~~ assessment has been completed. 3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** The MDS Coordinators and the Interdisciplinary team received education on OBRA required MDS assessments and facility required quarterly assessments, care plan development and implementation by the Quality assurance Nurse on 4/5/2012 and 4/10/2012.	5-1-12
{F 279} SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's	{F 279}		

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{F 279}	Continued From page 22 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, review of facility documentation, observation, and interview, the facility failed to complete a behavior care plan for three residents (#21, #35, #33) of thirty-nine residents reviewed. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-279 continues at an "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including the	{F 279}	Starting the week of April 23rd the DON/ADON or Quality Assurance Nurse will audit new admit and or readmitted resident medical records in fourteen to twenty days after admission to assessment and ensure a comprehensive care plan has been completed. Starting the week of April 23rd the DON/ADON, unit managers and or Quality Assurance Nurse will audit the medical record of new admit and or readmitted resident weekly for eight weeks and then PRN to ensure ~~an~~ assessment & interim care plan has been developed timely. **4. Corrective actions will be monitored to ensure the deficient practice will not reoccur:** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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{F 279}	Continued From page 24 deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 279}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to revise the care plan for one resident (#8) of thirty-nine residents reviewed. Resident #8 was admitted to the facility on October 9, 2006, with diagnoses including Diabetes Mellitus, Dementia, Osteoarthritis, and Chronic Obstructive Pulmonary Disease. After a	{F 280}	F 280 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** The care plan for resident # 8 was update on by the MDS Coordinator on 3/282012 2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents admitted to the facility have the potential to be affected by this allege deficient practice. Resident admitted or readmitted on or after 3/19/2012 had chart checks for updated care plans and any found had care plans updated as needed.	5-1-12

pg 35

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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BRISTOL NURSING HOME	281 NORTH STREET BRISTOL, TN 37625

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{F 280}	Continued From page 25 left hip fracture on February 10, 2012, the resident was readmitted to the facility on February 16, 2012. Medical record review of the Plan of Care last reviewed on February 17, 2012, revealed the care plan had only been updated to reflect physical therapy. Continued review revealed no revisions for the hip fracture, staples, mobility, or new devices. Interview with Minimum Data Set (MDS) Coordinator #1 on March 29, 2012, at 2:00 p.m., in the MDS office, confirmed the care plan was not updated after the readmission on February 16, 2012 for the hip fracture, staples, mobility, or new devices.	{F 280}	3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** The MDS Coordinators and the interdisciplinary team received education on OBRA required MDS assessments and facility required quarterly assessments, care plan development and implementation by the Quality assurance Nurse on 4/5/2012 and 4/10/2012. Starting the week of April 23rd the DON/ADON/ unit managers and or Quality Assurance Nurse will audit new admit and or readmitted resident medical records in the daily clinical meeting within twenty – four to seventy – two hours of admission Monday through Friday to ensure an interim plan of care has been implemented. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager,	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen administration for one resident (#1), and failed to provide nutritional supplements for one resident (#32) of thirty-nine residents reviewed. The findings included: Resident #1 was admitted to the facility on March 20, 2012, with diagnoses including Congestive Heart Failure, Diabetes, Kidney Failure, and	{F 281}		5-11-12

pg 32

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 25 left hip fracture on February 10, 2012, the resident was readmitted to the facility on February 16, 2012. Medical record review of the Plan of Care last reviewed on February 17, 2012, revealed the care plan had only been updated to reflect physical therapy. Continued review revealed no revisions for the hip fracture, staples, mobility, or new devices. Interview with Minimum Data Set (MDS) Coordinator #1 on March 29, 2012, at 2:00 p.m., in the MDS office, confirmed the care plan was not updated after the readmission on February 16, 2012 for the hip fracture, staples, mobility, or new devices.	{F 280}	Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen administration for one resident (#1), and failed to provide nutritional supplements for one resident (#32) of thirty-nine residents reviewed. The findings included: Resident #1 was admitted to the facility on March 20, 2012, with diagnoses including Congestive Heart Failure, Diabetes, Kidney Failure, and	{F 281}		

5-17-12

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{F 280}	Continued From page 25 left hip fracture on February 10, 2012, the resident was readmitted to the facility on February 16, 2012. Medical record review of the Plan of Care last reviewed on February 17, 2012, revealed the care plan had only been updated to reflect physical therapy. Continued review revealed no revisions for the hip fracture, staples, mobility, or new devices. Interview with Minimum Data Set (MDS) Coordinator #1 on March 29, 2012, at 2:00 p.m., in the MDS office, confirmed the care plan was not updated after the readmission on February 16, 2012 for the hip fracture, staples, mobility, or new devices.	{F 280}		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen administration for one resident (#1), and failed to provide nutritional supplements for one resident (#32) of thirty-nine residents reviewed. The findings included: Resident #1 was admitted to the facility on March 20, 2012, with diagnoses including Congestive Heart Failure, Diabetes, Kidney Failure, and	{F 281}	F 281 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** The charge nurse immediately increased the O2 to 4L as ordered. The Dietary manager immediately took a Mighty Shake up to resident # 32 on March 30, 2012. A physician order was obtained on 3/31/2012 to discontinue Ensure for resident # 32.	5-17-12

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(F 281)	Continued From page 26 Hypertension. Medical record review of the Minimum Data Set dated March 21, 2012, revealed the resident had no problem with decision making, had short term memory problems, and required extensive assistance with all activities of daily living. Review of a Physician's Admission Order dated March 20, 2012, revealed, "...O2 (Oxygen) 4L (Liters) NC (Nasal cannula)..." Observation on March 26, 2012, at 10:00 a.m., and March 27, 2012, at 9:25 a.m., revealed the resident lying in bed with oxygen infusing at 3.5 liters per nasal cannula. Observation and interview with a Licensed Practical Nurse (#2) on March 27, 2012, at 9:25 a.m., in resident's room, confirmed the oxygen was infusing at 3.5 liters per nasal cannula and confirmed the Physician's Orders was for 4 liters. Resident #32 was readmitted to the facility on January 18, 2012, with diagnoses including Pneumonia, Rectal and Anal Hemorrhage, Constipation, Paralytic Ileus, Adult Failure to Thrive, Hypertension, Senile Dementia, Osteoporosis, and Dyphagia. Medical record review of the Minimum Data Set (MDS) dated February 2, 2012, revealed the resident had short and long term memory impairment and moderate cognitive skills for daily decision making. Interview with the resident's son on March 29,	(F 281)	**2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** The DON, ADON, and or Dietary manager reviewed the chart of all residents with an order for a dietary supplement on 4/17/2012 to ensure a physician order had been obtained for the appropriate dietary supplement. The DON, ADON, and or Nurse Manage reviewed residents with O2 to check for correctness of liter completed April 26, 2012. Starting the week of April 23rd the charge nurses, ADON, DON will observe the meal tray of residents with an order for a dietary supplement to ensure the supplement is sent up on the meal tray. **3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Starting the week of April 23rd the charge nurses, ADON, DON will audit meal trays daily Monday through Friday to ensure Dietary supplements are served as	5-11-12

pg 39

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 281}	Continued From page 27 2012, at 8:35 a.m., in the resident's room, revealed the resident was fed by the family daily and had not received Ensure (a dietary supplement) on the breakfast tray for "a month". Medical record review of the Physician's Order dated March 1-31, 2012 revealed " ...ENSURE LIQ VANILLA GIVE AS DIRECTED with meals STOCK ITEM Start 01/19/12..." Observation on March 30, 2012, at 8:10 a.m., in the resident's room when the breakfast tray was delivered, revealed orange juice and milk on the tray, no Ensure was on the tray. Review of the tray card on the tray, dated March 30, 2012, revealed "...COFFEEE OR HOT TEA- 1 CUP, MILK - 1 CUP, FRUIT JUICE - 4 OZ. ENSURE - 1 IND..." Interview with the Certified Dietary Manager (CDM) confirmed the facility used the last Ensure on Monday, March 19, 2012, and the facility had a doctor's order to substitute Mighty Shakes (different brand dietary supplement) for those residents with orders for supplements with meals. Continued interview with the CDM confirmed the facility was in the process of reevaluating the residents for dietary supplements, the doctor's orders for the substitution had not been added to the medical records on Second Tennessee (where the resident lived), and the facility had not provided the Ensure or the Mighty Shake for this resident since March 19, 2012.	{F 281}	ordered daily at lunch and supper for four weeks and then PRN.. Starting the week of April 23rd the DON\ADON and or Nurse Mangers will make checks of residents with O2 to ensure the correct liter. The checks will b done 3 times a week for 4 weeks then weekly for 8 weeks. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur:** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-17-12
{F 314} SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	{F 314}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 314)	Continued From page 28 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of manufacturer's recommendations, policy review, and interview, the facility failed to consistently and appropriately provide complete skin assessments and interventions to prevent pressure, which caused harm for one resident (#8) of thirty-nine residents reviewed, who developed a pressure ulcer on the left heel. The findings included: Resident #8 was admitted to the facility on October 9, 2006, with diagnoses including Diabetes Mellitus, Dementia, Osteoarthritis, and Chronic Obstructive Pulmonary Disease. After a left hip fracture on February 10, 2012, the resident was readmitted to the facility on February 16, 2012. Medical record review of the Minimum Data Set (MDS) dated January 15, 2012, revealed the resident required extensive assistance with decision making, had short and long term memory problems, was incontinent of bowel and bladder, required extensive assistance with transfers, was totally dependent for mobility, and was at risk for developing pressure ulcers.	(F 314)	F314 1 **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice:** A skin assessment was completed on resident # 8 on 3/28/2012. An order was obtained to discontinue the waffle boots and implement a Zero Suspension pressure reduction device. 2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by this alleged deficient practice The charge nurses completed skin assessment on all residents in the facility from 4/9/2012 to 4/11/2012 an wounds found where addressed and care planned. A skin assessment will be completed on all residents upon admission.	5-11-12

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{F 314}	Continued From page 29 Medical record review of the Plan of Care last reviewed on January 19, 2012, revealed "...maintain intact skin integrity through this review...observe skin during bathing for areas of redness ..." Medical record review of the Braden Scale for Predicting Pressure Sore Risk updated October 28, 2011, revealed a score of fifteen (indicating the resident was at mild risk) on the facility's tool for predicting pressure sore risk. Medical record review of an Admission Evaluation and Interim Care Plan, dated February 16, 2012, revealed a Braden Skin score of fourteen (moderate risk) and the skin assessment for the right and left heels revealed no abnormalities. Medical record review of a facility treatment record dated March 1, 2012, through March 31, 2012, revealed "...waffle boots on when in bed to help keep off load heels ..." Review of manufacturer's recommendations "Foot Waffle Brand Air Cushions", not dated, revealed "...visually or hand check that the heel is off the bed. A hand check should be performed at every nursing shift ..." Review of the facility's Pressure Ulcer Risk Assessment policy, revised October 2010, revealed, "...skin will be assessed for the presence of developing pressure ulcers on a weekly basis...the at-risk resident needs to be identified and have interventions implemented promptly to attempt to prevent pressure ulcers ..."	{F 314}	**3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur:** Charge nurses will complete a weekly skin assessment on all residents as scheduled. The nursing assistants will notify the charge nurses of skin issues when noted on shower days and or during ADL care. DON, ADON, Quality Assurance Nurse, and or Treatment Nurse will provide training to the nursing staff regarding pressure ulcer prevention by 4/20/2012. Nursing staff will be in serviced prior to allowing them to work the floor. In services will be added to the orientation packet. Starting the week of April 23rd the DON\ADON and or Nurse Managers wil make observations of patients with wounds ensuring treatment and preventative devices are in place 2 times . day for 7 days then daily for 7 days. Starting the week of April 23 the DON, ADON, or Unit managers will audit the weekly skin assessment book weekly for four weeks and then PRN.to ensure compliance.	5-12-12

Pg 42

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{F 314}	Continued From page 30 Medical record review revealed no documentation of weekly skin assessments. Observation on March 27, 2012, at 10:30 a.m., in the men's shower room, revealed a dime size wound to the left heel with escar (full thickness tissue loss). Observation on March 27, 2012, at 3:06 p.m., in the resident's room, revealed the resident lying in the bed sleeping with the waffle boots lying on a chair at the bottom of the bed. Observation and interview with Licensed Practical Nurse (LPN) #4 on March 27, 2012, at 3:12 p.m., in the resident's room, confirmed the presence of a wound on the left heel and the wound was related to pressure on the resident's heals. Observation and interview with Licensed Practical Nurse (LPN) #9 on March 27, 2012, at 3:21 p.m., in the resident's room, confirmed the resident was lying in bed with the waffle boots off. Observation and interview with Certified Nursing Assistant (CNA) #2 on March 28, 2012, at 1:48 p.m., in the resident's room, confirmed the resident's heel was resting against the sheet. Observation and interview with LPN #6 on March 28, 2012, at 1:52 p.m., in the resident's room, confirmed the resident's heels were touching the bed and the resident had been wearing the waffle boots since returning from the hospital. Observation and interview with LPN #7 on March 28, 2012, at 1:55 p.m., in the resident's room, confirmed waffle boots were supposed to float	{F 314}	4. Corrective actions will be monitored to ensure the deficient practice will not reoccur: DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager,	5-1-12

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{F 314}	Continued From page 31 heels and "no one has looked at boots" to verify that the residents heels were floated. Continued interview confirmed heels were not floated. Observation and interview with LPN #9 on March 28, 2012, at 2:46 p.m., confirmed the resident's heels were "elevated very little, if any" and the waffle boots did not keep pressure off the resident's heel. Further interview confirmed the wound was identified on March 14, 2012, was black escar and the measurements were length 1.5 centimeters (cm) by 1.5 cm wide. Further interview confirmed that the resident had not been getting weekly skin assessments prior to March 5, 2012. Telephone interview with the Resident's physician on March 29, 2012, at 1:30 p.m., confirmed the physician was not aware the waffle boots did not elevate the heel off the bed and the pressure ulcer could have been avoided if the heels had been elevated off the bed.	{F 314}	F315 1. Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice: Resident #8 skin condition was assessed by the treatment nurse, order was obtained from the Physician for a hydrocolloid dressing and the care plan updated on 3/28/2012. The charge nurse completed a Bowel and Bladder assessment on Resident # 9 on 3/29/2012. Resident was placed on a check and change every two hours due to diagnosis of Dementia. Care plan for resident # 9 was updated or 3/29/2012.	5-12-12
{F 315} SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced	{F 315}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 315}	Continued From page 32 by: Based on medical record review, observation, and interview the facility failed to provide the appropriate incontinence care for one resident (#8), failed to complete a bowel and bladder assessment for one resident (#4), and failed to reassess the decline of bladder function for one resident (#9) of thirty-nine residents reviewed. The facility's failure to provide incontinence care caused harm to resident #8. The findings included: Resident #8 was admitted to the facility on October 9, 2006, with diagnoses including Diabetes Mellitus, Dementia, Osteoarthritis, and Chronic Obstructive Pulmonary Disease. After a left hip fracture on February 10, 2012, the resident was readmitted to the facility on February 16, 2012. Medical record review of the Minimum Data Set dated January 15, 2012, revealed the following: the resident had short and long term memory problems, was always incontinent of bowel and bladder, required extensive assistance for transfers, and was totally dependent on staff for mobility. Medical record review of a care plan last reviewed on January 19, 2012, revealed "...cleanse perineal area after each incontinent episode...reposition resident q (every) 2hr (hours)..." Interview with CNA #6 on March 27, 2012, at 8:14 a.m., in the 2nd Tennessee day room, confirmed the resident would receive incontinence care	{F 315}	The charge nurse completed a Bowel and Bladder assessment on Resident # 4 on 3/29/2012. Resident was placed on a check and change every two hours due to diagnosis of Dementia. Care plan for resident # 4 was updated on 3/29/2012. 2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected by the alleged deficient practice. The charge nurses, unit managers, Quality Assurance Nurse, DON and or ADON will complete an audit on 100% of the medical records to ensure a bowel and bladder assessment was completed last quarter by 5/11/12.. All incontinent residents were identified thru observation DON\ADON, Nurse Manager, or Quality Assurance Nurse will provide education on peri care, turning and repositioning to the CNAs. CNAs will be in serviced prior to being allowed to work the floor. In service will be added to the orientation packet.	5-11-12

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(F 315)	Continued From page 33 within the hour and the surveyor would observe incontinence care. Continual observation on March 27, 2012, from 7:30 a.m. until 10:30 a.m., revealed the resident sitting in a reclined Geri chair (reclining chair) in the 2nd Tennessee day room. Observation at 10:30 a.m., revealed the resident was taken to the men's shower room by Certified Nursing Assistant (CNA) #3 for incontinence care. Observation, at that time, revealed excoriation (abrading of skin) of the scrotum, perineal, and inner thighs. Continued observation revealed the resident was making grunting sounds during incontinence care. Interview with CNA #3 and CNA #4 on March 27, 2012, at 10:30 a.m., outside the men's shower room, confirmed CNA #6 had to leave the facility and a hand-off report (report between staff given for continuity of care) was not given to them by CNA #6 before CNA #6 left the facility and they were unaware of how long the resident had been sitting in the Geri chair or how long it had been since incontinence care was done. Interview with CNA #3 on March 27, 2012, at 10:34 a.m., confirmed the adult brief was soaked with urine and the pelvic area was excoriated. Observation and interview with Licensed Practical Nurse (LPN) #4 on March 27, 2012, at 10:43 a.m., in the men's shower room, confirmed the pelvic area was excoriated, the resident expressed pain upon touch, and the area was "not red when (resident) had a shower last Friday (March 23, 2012)". Continued interview, at that time, confirmed residents were to be checked	(F 315)	3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur:** Starting the week of April 23rd the DON/ADON and or the Quality Assurance Nurse will audit 5 charts per week x 4 weeks and then 3 charts per week for 4 weeks and then PRN. To ensure bowel and bladder assessments have been completed. Starting the week of April 23rd the DON/ ADON, Unit Managers and or Quality Assurance Nurse will audit the medial record of residents admitted or readmitted to the facility within twenty-four to seventy two hours of admission to ensure a bowel and bladder assessment has been completed. Starting the week of April 23rd the DON/ ADON, Unit Managers and or Quality Assurance Nurse will audit the medial record of residents admitted or readmitted to the facility within twenty-four to seventy two hours of admission to ensure a bowel and bladder assessment has been completed. Starting the week of April 23rd the DON\ADON, or Nurse Manager will make observations daily on incontinent residents to check for incontinence. If resident is found wet, the resident will be changed immediately and a skin assessment completed.	5-11-12

pg 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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{F 315}	Continued From page 34 and changed if needed every two hours and "sitting in a Geri chair for three hours without cleaning and changing resident could contribute to excoriation". Resident #9 was admitted to the facility on January 30, 2003, with diagnoses including Altered Mental Status, Acute Renal Failure, and Diabetes Mellitus. Medical record review of the most recent Minimum Data Set (MDS) revealed the resident's Brief Interview for Mental Status (BIMS) score to be fourteen which indicates cognitively intact. Medical record review of the Annual MDS completed on June 26, 2011, revealed the resident was always continent of bowel and bladder. Continued review of the most recent MDS completed February 26, 2012, revealed the resident was frequently incontinent of bladder. Interview and medical record review with the Minimum Data Set (MDS) coordinator #1 and #2 and the Director of Nursing, in the MDS office, on March 29, 2012, at 9:20 a.m., confirmed the resident had not been re-evaluated for a bladder program. Resident #4 was admitted to the facility on September 2, 2011, for diagnoses including Dementia, Congestive Heart Failure, Pericardial Disease, and Osteoarthritis. Medical record review of the Minimum Data Set (MDS) dated September 11, 2011, revealed the resident had short and long term memory loss, required extensive assistance with transfers, and	{F 315}	4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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{F 315}	Continued From page 35 was frequently incontinent of bladder and always incontinent of bowel. Medical record review of the Evaluation for Bowel and Bladder Retraining and Progress Notes dated September 13, 2011, revealed there was no documentation the resident had been assessed for bladder and bowel retraining. Interview with Licensed Practical Nurse (LPN) #6 on March 29, 2012, at 3:42 p.m., at the 2nd Tennessee nurses station, confirmed the evaluation for bowel and bladder had not been completed.	{F 315}		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, interview, facility policy review, and review of facility documentation, the facility failed to provide supervision of aggressive behaviors for two residents (#21 and #35) with behavioral problems; failed to ensure safe bed rails for one resident (#8); and failed to ensure supervision for wandering for one resident (#17) of thirty-nine residents reviewed.	{F 323}	F 323 483.25 (h) Free of Accident Hazards/Supervision/Devices The facility will ensure that the residents' environment is as free of accidents hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? • On March 27, 2012 the full side rails were immediately removed from the bed. The resident was placed in a Geri-chair. The residents' old bed was replaced with a new bed with assist rails within one hour. • A side rail assessment and the care plan were updated on 4/9/2012 for resident # 8 by the unit manager. The unit manager notified the staff of the updated care plan immediately. . • It was reported that on 1/18/2012 resident #21 was observed exiting the room of Resident # 17 and her brief was undone. Resident # 21 was transferred to another facility on 3/30/2012.	5-11-12

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(F 323)	Continued From page 36 The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-323 continues at an "E" level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence 100% of all side rail assessments were completed to ensure no opportunity for entrapment. The facility provided evidence of in-services related to policies and procedures for reporting and investigating abuse immediately; care of residents with Dementia and Dementia related behaviors; implementation and interventions to prevent behaviors; and implementation and interventions after a behavior has occurred. The facility reviewed care plans for all residents currently with behavior problems and on behavior management to ensure all interventions are on the care plans and the resident care guides to ensure staff are aware of proper interventions. The facility completed mood and behavior assessments, and updated care plans related to mood and behavior.	(F 323)	• The care plan for res. # 17 was updated by social services, MDS Coordinator and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • On 4/11/2012 the care plan for res. # 17 was updated to include: redirect the resident with activity diversion when wandering such as folding wash clothes, looking at the sand hour glass and or magazines. • The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident #17 for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. • The charge nurse completed a skin assessment on 1/20/2012 which indicated a right hip wound was present however there was no indication of bruising or redness anywhere on the resident's body. • The charge nurse completed Skin assessments dated 3/18/2012, 3/22/2012 and 3/26/2012 all indicate no new skin issues. • Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am. • Resident #21 was transferred to Bristol Regional Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. This resident will not be readmitted to the facility.	5-11-12

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{F 323}	Continued From page 37 The facility provided evidence daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing Assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistants to eight residents) for 7P-7A shift. Staffing will be increased to six Nursing Assistants on the 7A-7P shift and five Nursing Assistants on the 7P-7A shift. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 323}	• The nurses' note dated 2/29/2012 at 7:30 pm revealed that resident # 6 was setting in her wheelchair and resident # 35 put his hands around her neck trying to choke her. Resident #35 was redirected to his room. Res. # 6 was put to bed. No red marks or bruising noted and the resident had no complaint of pain at the time of the incident. The family and MD were notified of the incident. • The social worker completed a PHQ9 assessment on 3/31/2012 to assess resident # 6 and res. # 35 for signs and symptom of depression and to identify possible changes in signs and symptoms of mood distress since his last assessment. The assessments revealed that there was no change from the residents 'baseline • The charge nurse completed a Skin assessment on resident #6 on 3/18/2012; 3/22/2012 and 3/26/2012.There was no indication of bruising or redness anywhere on the resident body. • The care plan for res # 6 was updated by social services, MDS Coordinator, Social Worker and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • The Corporate Quality Assurance Nurse and the Sr. Director of clinical services immediately notified the charge nurses on duty of the changes made to the care plan. • The Director of Nursing updated resident care guides to ensure the nursing assistants were aware of the care plan changes on 4/11/2012. • The care plan was updated on res # 35 on 4/2/2012 with a new intervention to Place the resident on one on one observation and notify the M.D. and social services when the resident becomes aggressive with other residents.	5-11-12
{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	{F 332}		

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{F 323}	Continued From page 37 The facility provided evidence daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing Assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistants to eight residents) for 7P-7A shift. Staffing will be increased to six Nursing Assistants on the 7A-7P shift and five Nursing Assistants on the 7P-7A shift. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	{F 323}	• Charge nurses will place resident's on one to one observation and notify the MD and social services when any resident displays aggression of any type toward another resident. • The charge nurse and or nursing supervisor will assign a staff member to monitor a resident needing one on one observation. • The one on one observations are documented on a nurses note or an observations form. The observations are filed in the medical record at the end of each shift. • A side r\ail audit was completed on 100% of the beds in the facility to ensure there was no opportunity for entrapment. • The audit was completed by the Charge Nurses, DON, ADON, Corporate Quality Assurance Nurse, and the Corporate Director of Clinical Services on 3/30/2012. • A total of nine beds were replaced. • Skin assessments were completed by the charge nurses on all residents on 2nd Tennessee beginning 3/30/2012 through 4/4/2012 to identify unknown bruises and or abrasions. 2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken? • All residents on 2nd Tennessee may be affected by the same alleged deficient practice. However to ensure a safe environment for all residents who live on 2nd Tennessee Resident #21 was transferred to Bristol Regional Medical Center for an evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. The facility will not readmit the resident.	5-11-12
{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	{F 332}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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(F 323)	Continued From page 37 The facility provided evidence daily audits of the mood and behavior assessments and medication adjustments were called to the Physician. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing Assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistants to eight residents) for 7P-7A shift. Staffing will be increased to six Nursing Assistants on the 7A-7P shift and five Nursing Assistants on the 7P-7A shift. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and evaluated by the Quality Assurance Committee.	(F 323)	• On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive Officer, Corporate Director of clinical services had an informal Quality Assurance committee meeting to review the Staffing levels on 2nd Tennessee . The decision was made to increase staffing by 43% (4-staff members) on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift. • Staffing will be increased to six nursing assistants resulting in a C.N.A. to resident ratio of 1 to 7 on the 7A-7P shift and five nursing assistants resulting in a C.N.A. to resident ratio of 1 to 8 on the 7P – 7A shift as soon as the facility can maintain the new staffing levels. • To increase and retain the increased number of staff on 2nd Tennessee the facility has placed a newspaper ad locally, on Craig's list and, on Monster.com for C.N.A's, LPN's and RN's. • Offering a $500.00 new hire sign on Bonus for LPN's and C.N.A.'s. • Offering a $250.00 referral Bonus to current employee that refers other nursing staff that are hired and stay past ninety days. • A perfect attendance Bonus of an additional twenty-five cent per hour worked per pay period has been implemented for nursing assistants. • The charge nurses will utilize the Psychoactive Medication monthly flow record to document resident changes in mood and or behaviors. It is the responsibility of the charge nurses to notify the MD and social services of any mood and behavior changes.	5-11-12
(F 332) SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	(F 332)		

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{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	{F 332}		

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{F 332} SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	{F 332}		

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(F 332)	Continued From page 38 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, facility policy review, and interview, the facility failed to maintain a medication error rate of less than five percent for four medication errors of forty medications observed. The findings included: Resident #12 was admitted to the facility on February 8, 2012, with diagnoses including Vascular Dementia, Anxiety State, Depressive Disorder, and Emphysema. Medical record review of the monthly recapitulation physician's orders dated March 2012, revealed " ...Atrovent (inhaler)...2 puffs twice daily...Symbicort (inhaler)...2 puffs twice daily...Ventolin (inhaler)...2 puffs twice daily..." Facility policy review of Administering Medications through a Metered Dose Inhaler revealed, " ...allow at least one (1) minute between inhalations of the same medication and at least two (2) minutes between inhalations of different medications ..." Observation on March 27, 2012, at 8:15 a.m., revealed Licensed Practical Nurse (LPN) #4 administering medications to resident #12. Continued observation revealed the LPN obtained three inhalers from the medication cart and	(F 332)	F 332 **1. Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice:-** Resident #12 was assessed on3/31/12 by the charge nurse with no negative outcome. LPN #4 was re-educated by the Quality Assurance Nurse in regards to policy for administration of inhalers on 3/31/2012 Resident #14 was assessed 3/ 31/12 on by the charge nurse with no negative outcome. LPN #2 was educated on administration of pain medication by the Quality Assurance Nurse on 3/31/2012. MD was notified and order clarification was obtained. **2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents were identified by who is receiving inhalers and Tylenol for pain, were at risk to be affected by the same deficient practice. No other issues noted.	5-11-12

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{F 332}	Continued From page 39 without giving instruction or waiting between puffs or between inhalers administered the medications to the resident. Interview with LPN #4 at the 200 hall nurse's desk on March 27, 2012, at 9:40 a.m., confirmed that the facility policy for administration of inhalers was not followed. Resident #14 was admitted to the facility on April, 21, 2011, with diagnoses including Diabetes Mellitus, Atrial Fibrilation, and Dementia. Medical record review of the physician's recapitulation orders for March 2012, revealed "...pain relief tab (tablet)...for Tylenol...650 mg (milligrams)..." Observation of LPN #2 on March 27, 2012, at 4:48 p.m., revealed the LPN administered Acetaminophen (Tylenol) 500 mg to resident #14. Interview and medical record review with LPN #2 on March 27, 2012, at 4:52 p.m., confirmed the facility failed to administer the ordered dose by administering the 500 mg in place of the 650 mg.	{F 332}	3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur:** Week of April 23, DON, ADON, Quality Assurance or Pharmacy Consultant will observe medication pass 2xwk for 4 wks then weekly for 8 wks then prn. Week of April 23, DON, ADON or Quality Assurance Nurse will provide education to the licensed staff regarding medication administration will be completed by 5/11/12. All licensed staff will be in serviced before providing care to the residents. 4. **Corrective actions will be ensure the deficient practice will not reoccur:** DON/designee will report findings of audits to the Quality Assurance Committee monthly.. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12
{F 353} SS=K	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	{F 353}		

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pg 58

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{F 353}	Continued From page 40 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed to ensure adequate staffing and nursing supervision to ensure incidents of alleged abuse were reported and investigated for one resident (#21); to supervise two residents (#21, #35) with aggressive behaviors; to supervise one resident (#17) with wandering behaviors; to provide care to prevent development of pressure ulcers for one resident (#8); and to provide incontinence care to prevent skin excoriation for one resident (#8) of thirty-nine residents reviewed. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-353 continues at an "E" level citation (potential for more than minimal harm).	{F 353}	• On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive Officer, Corporate Director of clinical services had an informal Quality Assurance Committee meeting to review the Staffing levels on 2nd Tennessee. The decision was made to increase staffing by 43% (4-staff members resulting in a 1C.N.A to 7 residents) on the 7A-7P shift and increased by 25% (2 staff members resulting in 1 C.N.A. to 8 residents) on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing levels. • Resident # 35 was seen by Psychiatric Services on 3/27/2012 related to recent aggressive behaviors. Recommendations: Increase Exelon patch to 9.5 mg/24 hours. Topically for maximum cognitive benefit. Increase Seroquel XR 400 mg at 5pm daily for agitation and combative behavior. . • The care plan was updated for res. # 35 by the MDS Coordinator, Social Worker and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • The care plan for res. # 35 was updated on 4/2/2012 with a new intervention to Place the resident on one on one observation and notify the M.D. and social services when the resident becomes aggressive with other residents.	5-17-12

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{F 353}	Continued From page 41 The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation, facility policy review, and interview with facility staff including the administrative staff. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing Assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistant to eight residents) for 7P-7A shift. Staffing will be increased to six Nursing Assistants on the 7A-7P shift and five Nursing Assistants on the 7P-7A shift. The facility will remain out of compliance at an "E" level until it provides an acceptable Plan of Correction to include monitoring to ensure the deficient practice does not recur and the facility's corrective measures could be reviewed and	{F 353}	• Care plan was updated on 4/11/2012 on resident # 17 to redirect with activity diversion such as folding wash clothes and using sand bottle hour glasses and or the use magazine. When wandering throughout the facility; Place stop signs across the door way of residents who do not want visitors or who can not make their own decisions. • The Director of Nursing updated the resident care guide with the activity diversion of folding wash clothes and using sand bottle hour glasses and ,or the use magazine on 4/11/2012. • The unit manager reviewed the changes to the care guide with all nursing staff. • Changes are discussed during the nursing report at shift change. • The skin assessment for resident # 8 on 3/28/2012 revealed a sheared area. A physician order was obtained on 3/28/2012 for the area of shearing. • The responsible party was notified of the skin changes for resident #8 by Wound Care Nurse on 3/28/2012. • The Care plan for res. #8 was updated on 3-28-2012 by the Wound Care Nurse to include the need to provide incontinence care and reposition every hour. *2. How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?* All residents on 2nd Tennessee may be affected by the same alleged deficient practice. To prevent a reoccurrence of this alleged deficient practice the following changes has been implemented.	5-11-12

pg 60

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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PG 63

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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(F 353)	Continued From page 42	~~(F 362)~~	F 441 INFECTION CONTROL	
(F 441) SS=E	evaluated by the Quality Assurance Committee. 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	(F 441)	1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice:** The Charge Nurse assessed the wound on resident # 3 on 4/5/2012. There were no negative outcomes. The DON immediately placed an isolatio sign on res. # 5 door to notify visitors tha the resident is in isolation. The Charge nurse cleaned off the over bed table for Resident #13. The charge nurse cleaned off the medication cart and the monitor after passing medication to resident #15. The nursing assistant removed the clothing from the bathroom floor and housekeeping cleaned the bathroom for Resident #26. 2. **Identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Residents with orders for Accuchecks an or resident who independently toilet have the potential to be affected by the alleged deficient practice.	5-11-12

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{F 441}	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation,facility policy review, and interview, the facility failed to ensure infection control practices were maintain for four residents (#3, #5, #13, #15) and failed to maintain a sanitary environment for one resident (#26) of thirty-nine residents reviewed. The findings included: Resident #3 was admitted to the facility with diagnoses including Mental Disorder, Glaucoma, and Late Stage Dementia. Observation of a dressing change on March 27, 2012, at 10:25 a.m., in the resident's room, revealed the wound care nurse positioned the resident on the left side. Observation revealed the resident was incontinent of stool. The wound care nurse performed incontinence care and placed the dirty linens in a plastic bag. Observation revealed a cloth pad with fecal material under the resident's buttocks. Continued observation revealed the wound care nurse removed the gloves, washed the hands, applied clean gloves and continued the dressing change to the wound, on the resident's buttocks, without removing the soiled pad. Interview with the wound care nurse, on March 27, 2012, at 11:00 a.m., in the resident's room, confirmed the soiled pad had not been removed prior to the dressing change and aseptic	{F 441}	Resident receiving Accuchecks were observed with no negative outcomes noted. No other residents were identified in isolation. Resident bathrooms were checked with n other problems noted. 3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** DON/ ADON and or the Quality Assurance Nurse will provide training to the licensed nurses regarding infection control during dressing changes and maintaining infection control with by 5/11/2012. Licensed nurses will be in serviced prior to being allowed to work the floor. In service will be added to the orientation packet. Starting the week of April 23rd the DON/ADON/ Quality Assurance Nurse and or Nurse Manager will observe Treatment Nurse during dressing changes three times a week for four weeks and then PRN. Starting the week of April 23rd the DON/ADON/ Quality Assurance Nurse and or Pharmacy consultant will observe random licensed nurses obtain Accuchecks during medication pass weekly four weeks and then PRN.	5-11-12

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{F 441}	Continued From page 44 technique not been followed. Resident #5 was admitted to the facility on February 20, 2012, with diagnoses including Congestive Heart Failure, Atrial Fibrillation, and Generalized Anxiety. Medical record review of a Physician progress note dated February 28, 2012, revealed "...Shingles R (right) groin..." Observation on March 26, 2012, at 10:05 a.m., revealed resident #5 in bed resting and two biohazard barrels and an isolation cart inside the resident room. Continued observation revealed no signage on the door to alert visitors. Interview and medical record review with Licensed practical Nurse (LPN) #3 on March 26, 2012, at 10:10 a.m., revealed the resident was in isolation for shingles. Review of the facility policy for Equipment and Supplies Used During Isolation revealed, " ...contact precautions...signs used to alert...Place a sign at the doorway instructing visitors to report to the nurses' station before entering the room..." Observation and interview with the Director of Nursing (DON) on March 26, 2012, at 2:27 p.m., confirmed a sign was not placed, and the facility policy for contact precautions was not followed. Resident #13 was admitted to the facility on February 5, 2010, with diagnoses including Arthropathy, Diabetes Mellitus, and Chronic	{F 441}	The DON/ADON/ Quality Assurance Nurse and or staff development coordinator will In-service the nursing staff on infection control by 5/11/2012. Nursing staff will be in serviced prior to being allowed to work the floor. In service will be added to the orientation packet. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur:** DON and or ADON will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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{F 441}	Continued From page 45 Kidney Disease. Observation with LPN #5 on March 27, 2012, at 4:30 p.m., in the resident room revealed the resident sitting in a wheelchair. Continued observation at this time revealed the LPN obtained a lancet and stuck the finger of resident #13. Further observation revealed the LPN placed the finger with visible blood against a blood glucose strip, placed the strip with visible blood on top of the resident's overbed table. Interview with LPN #5 on March 28, 2012, at 9:30 a.m., on the 200 short hall, confirmed the overbed table was not cleaned prior to use and was not cleaned after use. Resident #15 was admitted to the facility on August 5, 2011, with diagnoses including Chronic Kidney Disease, and Diabetes Mellitus. Observation with LPN #3 on March 27, 2012, at 5:30 p.m., on the 100 hall revealed the LPN cleaned a blood glucose meter and placed the meter on the uncleaned medication cart. Continued observation revealed the LPN then took the meter that was placed on the unclean cart and completed an accucheck (fingerstick to obtain blood sample) for resident #15. Interview with LPN #3 on March 27, 2012, at 5:40 p.m., on the 100 hall confirmed the blood glucose meter was not cleaned after placing on the unclean cart, prior to performing the accucheck. Resident #26 was admitted to the facility on November 29, 2011, with diagnoses including Anemia, Hypertension, and Urinary Retention.	{F 441}		

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{F 441}	Continued From page 46 Observation on March 26, 2012, at 9:45 a.m., in the resident's room, revealed the resident sitting in a wheel chair watching the television. Continued observation of the room revealed articles of clothing lying on the bathroom floor and a moderate amount of brown substance on the commode seat. Observation on March 27, 2012, at 7:00 a.m., of resident's, revealed brown substance on the commode and the articles of clothing in bathroom floor. Interview on March 27, 2012, at 7:10 a.m., with the wound care nurse, confirmed the bathroom was not maintained in clean and sanitary condition.	{F 441}	F456 1. Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice The refrigerator on the 1 st. floor at the nurses' station was replaced on March 30 2012. 2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken Any resident that utilizes the refrigerator has the potential to be affected. Refrigerator temperatures will be documented on a temperature log daily by the dietary manager and or unit manager to ensure proper temperature control for food items on 1st Tennessee.	
{F 456} SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain one of two resident's refrigerators in a safe operating condition . The findings included: Observation on March 29, 2012, at 9:25 a.m., on the first floor nursing station, revealed the resident's refrigerator's temperature was set at 38 degrees. Continued observation revealed a build	{F 456}	3. Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur The nursing staff and or the Dietary manager will document refrigerator temperatures on the daily temperature log to ensure refrigerator temperatures are maintained in a safe operating condition with temperatures between 32 and 40 degrees Fahrenheit.	5-11-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37620

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 456}	Continued From page 47 up of ice causing the food items to be frozen. Interview with the Licensed Practical Nurse (#1) at that time confirmed the food items were frozen. Interview with the Dietary Manager on March 29, 2012, at 10:35 a.m., on the second floor nursing station, confirmed the first floor resident's refrigerator had recently been defrosted and needed to be replaced. Continued interview confirmed the refrigerator had not been maintained in a safe operating condition.	{F 456}	Starting the week of April 23rd the unit manager will audit temperature logs daily for four weeks and then PRN to ensure the temperature has been documented on the temperature log and to ensure that there is no ice build up in the refrigerator. The DON, ADON and or Quality Assurance nurse and or Dietary manager will in-service all staff on maintaining refrigerators in a safe operating condition and documenting refrigerator temperatures by 5/11/2012. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur:** The DON and or Dietary manager will report findings of audits to the Quality Assurance Committee monthly for three months and then PRN.. The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12
{F 465} SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for all residents on two of two nursing units observed. The findings included: Observations of the facility on March 27, 2012, from 9:18 a.m., until 10:13 a.m., and observations and interviews on March 29, 2012, from 8:08 a.m., until 9:10 a.m., with the Maintenance Director and at 1:35 p.m., with the Housekeeping Supervisor confirmed the following: 2 of 2 men's central baths and 2 of 2 women's central baths had multiple cracked and missing tiles, holes in	{F 465}		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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{F 456}	Continued From page 47 up of ice causing the food items to be frozen. Interview with the Licensed Practical Nurse (#1) at that time confirmed the food items were frozen. Interview with the Dietary Manager on March 29, 2012, at 10:35 a.m., on the second floor nursing station, confirmed the first floor resident's refrigerator had recently been defrosted and needed to be replaced. Continued interview confirmed the refrigerator had not been maintained in a safe operating condition.	~~{F 456}~~	F465 1. **Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** The tiles in the men's/women's central bathrooms that were cracked, missing, or had holes will be replaced by a licensed contractor and or maintenance. Maintenance will remove the mold from tiles and grout. The laminate covering missing on doors will be repaired a licensed contractor or maintenance. Holes in bathrooms or resident room's doors will be repaired by a licensed contractor or maintenance. Knobs missing from resident room drawers will be replaced by maintenance. The broken tiles in resident bathrooms will be replaced by a licensed contractor or maintenance. The rusted grab bars in resident bathrooms will be replaced by a licensed contractor and or Maintenance.	
{F 465} SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for all residents on two of two nursing units observed. The findings included: Observations of the facility on March 27, 2012, from 9:18 a.m., until 10:13 a.m., and observations and interviews on March 29, 2012, from 8:08 a.m., until 9:10 a.m., with the Maintenance Director and at 1:35 p.m., with the Housekeeping Supervisor confirmed the following: 2 of 2 men's central baths and 2 of 2 women's central baths had multiple cracked and missing tiles, holes in	{F 465}		

5-17-12

pg 70

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 465}	Continued From page 48 the shower tiles, and mold in the showers and grout; laminate covering missing from at least three resident room doors; a hole in one resident's bathroom door; a knob missing from the dresser with an exposed screw for one room; broken tiles in four resident's bathrooms; rusted metal at the bottom of door frames for at least five resident rooms; rusted grab bars in at least three resident bathrooms; sheet rock pulled away on walls of one resident bathroom and two resident rooms; a tile missing from the floor of 1st TN (Tennessee) short hall; and the plastic covering missing from one central bath doorframe. Interview with the Maintenance Director on March 29, 2012, from 8:08 a.m., until 9:10 a.m., while touring the facility, confirmed the facility had plans to renovate and the facility was in need of maintenance and renovations.	{F 465}	The tiles missing from the Short hall on 1st TN will be replaced by a licensed contractor and or maintenance. Maintenance and or a licensed contractor will replace the plastic covering missing from the central bath door frame. A licensed contractor or maintenance wil repair and paint the Metal door frames. All of the above repairs will be complete by May 4, 2012.	
{F 488} SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to firmly secure handrails on two of two floors. The findings included: Observation on March 29, 2012, from 8:08 a.m., until 9:10 a.m., with the Maintenance Director, revealed five of forty-seven hand rails in the halls,	{F 488}	2. **Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by alleged deficient practice. A room to room and hall by hall inspection will be completed by the Chief Executive Officer, Regional Vice President of operations and the maintenance director by 5/4/2012 to identify other areas in the facility where the same deficient practice might exist. Any deficient practice identified will be corrected through replacement or repair.	5-11-12

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BRISTOL NURSING HOME	281 NORTH STREET BRISTOL, TN 37625

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{F 465}	Continued From page 48 the shower tiles, and mold in the showers and grout; laminate covering missing from at least three resident room doors; a hole in one resident's bathroom door; a knob missing from the dresser with an exposed screw for one room; broken tiles in four resident's bathrooms; rusted metal at the bottom of door frames for at least five resident rooms; rusted grab bars in at least three resident bathrooms; sheet rock pulled away on walls of one resident bathroom and two resident rooms; a tile missing from the floor of 1st TN (Tennessee) short hall; and the plastic covering missing from one central bath doorframe. Interview with the Maintenance Director on March 29, 2012, from 8:08 a.m., until 9:10 a.m., while touring the facility, confirmed the facility had plans to renovate and the facility was in need of maintenance and renovations.	{F 465}	3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Starting the week of April 23rd Daily rounds Monday through Friday will be conducted by the Chief Executive Officer to identify any areas of concern that affec a safe, functional, sanitary and comfortable environment. If issues are identified, a Work order will be completed and given to maintenance to correct the issues identified. The Chief Executive Officer will review Work orders with maintenance staff weekly to monitor progress or completion of tasks.	
{F 468} SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to firmly secure handrails on two of two floors. The findings included: Observation on March 29, 2012, from 8:08 a.m., until 9:10 a.m., with the Maintenance Director, revealed five of forty-seven hand rails in the halls,	{F 468}	4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur :** The Chief Executive Officer will report findings of daily rounds to the Quality Assurance Committee monthly for four months. . The Quality Assurance committee (Administrator, Director of Nursing, Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	5-11-12

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{F 468} SS=D	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to firmly secure handrails on two of two floors. The findings included: Observation on March 29, 2012, from 8:08 a.m., until 9:10 a.m., with the Maintenance Director, revealed five of forty-seven hand rails in the halls,	{F 468}	**F 468 1. Corrective Action(s) will be accomplished for those resident found to been affected by the deficient practice** Any loose handrails identified throughout the facility were firmly secured on April 5th -6th, 2012 by the maintenance Staff. **2. Identify other residents to having the potential to be affected by the same deficient practice and what corrective action will be taken** All residents have the potential to be affected by alleged deficient practice. Checking for loose handrails is now a par of the weekly preventative Maintenance schedule. If any loose handrails are identified, they will be firmly secured as soon as possible but not to exceed 24 hours.	5-11-12

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{F 468}	Continued From page 49 were not attached to the wall securely. Interview with the Maintenance Director on March 29, 2012 at 9:10 a.m., in the hall on first floor, confirmed the hand rails were not firmly attached to the wall.	{F 468}	3. **Measures/systemic changes implemented to ensure the alleged deficient practice does not reoccur** Starting the week of April23rd the maintenance department will conduct a weekly handrail check as part of preventive maintenance schedule. Starting the week of April 23rd the Administrator will also check handrails as part of regular facility rounds. A Work order will be submitted if loose handrails are identified. The Administrator will monitor the preventive maintenance schedule or handrail weekly for 3 weeks and then PRN with the maintenance staff to ensure compliance. An identification of loose handrails will be corrected as soon as possible but not to exceed 24 hours.	
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed to be administered in a manner to ensure effective systems were in place to identify and investigate incidents of alleged abuse perpetrated by one resident (#21) with three residents (#17, #32, and #36); to formulate and implement a behavior care plan for two residents (#21 and #35) with physically aggressive behaviors; and to provide adequate staff for supervision of aggressive behaviors for two residents (#21 and #35) with behavioral problems. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-490 continues at an "E"	{F 490}		

5-11-12

83

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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{F 468}	Continued From page 49 were not attached to the wall securely. Interview with the Maintenance Director on March 29, 2012 at 9:10 a.m., in the hall on first floor, confirmed the hand rails were not firmly attached to the wall.	{F 468}	The Maintenance Director will report findings to the QA meeting and the monthly safety meetings. 4. **Corrective actions will be monitored to ensure the deficient practice will not reoccur :** The Maintenance Director will report findings of audits to the Quality Assurance Committee monthly. The Quality Assurance committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Medical Director, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will make recommendations to revise or improve the process and determine when compliance has been achieved.	
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed to be administered in a manner to ensure effective systems were in place to identify and investigate incidents of alleged abuse perpetrated by one resident (#21) with three residents (#17, #32, and #36); to formulate and implement a behavior care plan for two residents (#21 and #35) with physically aggressive behaviors; and to provide adequate staff for supervision of aggressive behaviors for two residents (#21 and #35) with behavioral problems. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-490 continues at an "E"	~~{F 490}~~		

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{F 468}	Continued From page 49 were not attached to the wall securely. Interview with the Maintenance Director on March 29, 2012 at 9:10 a.m., in the hall on first floor, confirmed the hand rails were not firmly attached to the wall.	{F 468}	F490 483.75 Administration / Resident well-Being .	
{F 490} SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility documentation, interview, and review of facility policy, the facility failed to be administered in a manner to ensure effective systems were in place to identify and investigate incidents of alleged abuse perpetrated by one resident (#21) with three residents (#17, #32, and #36); to formulate and implement a behavior care plan for two residents (#21 and #35) with physically aggressive behaviors; and to provide adequate staff for supervision of aggressive behaviors for two residents (#21 and #35) with behavioral problems. The facility provided a Credible Allegation of Compliance on April 11, 2012. A revisit conducted on April 16, 2012, revealed the corrective actions implemented on April 11, 2012, removed the Immediate Jeopardy. Non-compliance for F-490 continues at an "E"	{F 490}	1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? 5-11-12 • On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive Officer, Corporate Director of clinical services reviewed the Staffing levels on 2nd Tennessee and decided to increase staffing by 43% (4- staff members resulting in a I.C.N.A to 7 residents) on the 7A-7P shift and increased by 25% (2 staff members resulting in I C.N.A. to 8 residents) on the 7P -7A shift. Staffing will be increased to six nursing assistants on the 7A-7P shift and five nursing assistants on the 7P – 7A shift as soon as the facility can maintain the new staffing level • Resident # 21 was placed on fifteen minute observation on 3/30/2012 at 10:30 am until he was transferred to another facility. • Resident #21 was transferred to Bristol Regional Medical Center for an Evaluation and placement to a behavior unit on 3/30/2012 at 4:00pm. This resident will no be readmitted to the facility. 5-11-12 • The social worker completed a PHQ9 assessment Res. # 17 on 3/31/2012 to assess this resident for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline.	

Pg. 78

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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{F 490}	Continued From page 50 level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation,facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistant to 8 residents) for 7P-7A shift. Staffing will be increased to six nursing assistant on the 7A-7P shift and five nursing assistants on the 7P-7A shift. The facility provided evidence of in-services for all staff and random audits to ensure compliance for care of residents with Dementia and Dementia related behaviors; Implementation and interventions to prevent physical or sexual assaults; and implementation and interventions after a behavior has occurred and appropriate Physician notification. The facility provided evidence of abuse training, which included the Elder Abuse Act, for all staff. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or	{F 490}	• A skin assessment was completed by the charge nurse on Res. # 17 on 1/20/2012 which indicated a right hip wound was present however there was no indication of bruising or redness anywhere on the resident's body. • The charge nurse completed Skin assessments dated 3/18/2012, 3/22/2012 and 3/26/2012 all indicate no new skin issues. • The care plan was updated on res. # 17 by social services, MDS Coordinator and Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • On 4/9/2012 the care plan was updated to include: redirect the resident with activity diversion when wandering such as folding wash clothes, looking at the sand hour glass and or looking at magazines.. • The nurses note for Resident #32 dated 1/13/2012 at 10:00 am states the resident is on antibiotics for a UTI. Resident gestures with c/o generalized discomfort, the MD gave a new order for Lortab. The resident's son was made aware as he was visiting at the time. • The nurses' note dated 1/14/2012 states the resident "having questionable bleeding from rectal area. MD notified with new orders to send resident to ER for evaluation and treatment. RP was notified of residents' status and aware of resident going to the ER." Nurse's note dated 1/14/2012 at 6:00pm states the resident was admitted to BRMC with a diagnosis of Pneumonia. The hospital was not notified of the alleged sexual assault.	5-11-12

PB 79

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(F 490)	Continued From page 50 level citation (potential for more than minimal harm). The findings included: Validation of the Credible Allegation of Compliance was accomplished through medical record review, observation,facility policy review, and interviews with facility staff including the administrative staff. The facility provided evidence of increased staffing for the 2nd Tennessee floor by 43% (4-staff members resulting in one Certified Nursing assistant to seven residents) on the 7A-7p shift and increased by 25% (two staff members resulting in one Certified Nursing Assistant to 8 residents) for 7P-7A shift. Staffing will be increased to six nursing assistant on the 7A-7P shift and five nursing assistants on the 7P-7A shift. The facility provided evidence of in-services for all staff and random audits to ensure compliance for care of residents with Dementia and Dementia related behaviors; Implementation and interventions to prevent physical or sexual assaults; and implementation and interventions after a behavior has occurred and appropriate Physician notification. The facility provided evidence of abuse training, which included the Elder Abuse Act, for all staff. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or	(F 490)	• Resident # 32 was readmitted to the facility on 01/18/2012. The discharge summary list the following: Admitting diagnosis- Pneumonia, Rectal bleed with heme- positive stool, obstipation, Dementia. With an additional discharge Diagnosis of Gastrointestinal bleed. The hospital course on the discharge summary listed the following: A 95 year old white female with a history of dementia, unable to provide any significant history, had bright red blood in her diaper. The patient found to have UTI and Pneumonia treated. The patient had a CT scan, which shows stool but no evidence of any blockage. • The social worker completed a PHQ9 assessment on resident # 32 on 3/31/2012 to assess for signs and symptoms of depression and to identify possible changes in signs and symptoms of mood distress since her last assessment. The assessment revealed that there was no change from the residents' baseline. • A skin assessment was completed on res. # 32 on 1/18/2012. The skin assessment revealed no bruising or redness any where on the resident's body. • Resident # 32 care plan was updated by social services, MDS Coordinator Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors. • The care plan was updated by social services, MDS Coordinator, Social Services, Quality Assurance Nurse and Sr. Director of clinical services on 03/31/2012 to reflect the need to notify the MD and social services of changes in mood and behaviors.	5-1-12

Pg 80

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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Pg. 8.1

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pg. 82

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Pg. 83

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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pg. 84

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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pg. 86

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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5/1-12

R8.57

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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BRISTOL NURSING HOME	281 NORTH STREET BRISTOL, TN 37625

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(F 490)	Continued From page 51 inappropriate behaviors and to report these behavior incidents. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continue monitoring to ensure the deficit practice does not recur and the facility's corrective measure would be reviewed and evaluated by the Quality Assurance Committee.	(F 490)	• *Quality Assurance Committee will review findings and make recommendation to improve the process of communication related to residents maximum assistance level required by nursing staff for safe ambulation and transfers and determine when compliance has been reached.* *Quality Assurance Committee will review findings and make recommendation to improve the process for having equipment needed to safely meet resident needs and determine when compliance has been reached.*	
(F 520) SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	(F 520)	*The Chief Executive Officer will monitor the compliance of the Plan of Correction thru observation and the Quality Assurance process.*	

pg. 83

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(F 520) SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}	F520 Quality Assurance: 483.75 1. What corrective actions(s) will be accomplished for those residents found to have been affected by the alleged deficient practice? *The following corrective action was completed for each resident found to have been affected by the alleged deficient practice* • On 3/30/2012 members of the quality assurance committee, Director of Nursing, Assistant Director of Nursing and or the Chief Executive Officer, Corporate Director of clinical services and Corporate Quality Assurance Nurse had an informal quality assurance meeting to develop a plan to stop the immediacy of the Jeopardy. The following plan was put in place: • The Staffing levels on 2nd Tennessee were increase staffing by 43% (4- staff members) on the 7A-7P shift and increased by 25% (2 staff members) on the 7P -7A shift.	

pg. 89

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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pg. 90

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/18/2012
FORM APPROVED
OMB NO. 0938-0391

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	445498	A. BUILDING _____ B. WING _____	R 04/16/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRISTOL NURSING HOME	261 NORTH STREET BRISTOL, TN 37625

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4-11-12

BS. 91

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Pg. 92

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pg. 93

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Pg. 94

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Pg. 95

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pg. 54

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(F 520)	Continued From page 53 provided evidence of in-services for all staff related to Abuse and Dementia training including the Elder Abuse Act. Care plans were reviewed and updated to ensure current interventions. Random interviews with facility staff during the revisit confirmed they had received in-services related to dementia residents and how to care for the residents who displayed aggressive or inappropriate behaviors and to report these behavior incidents. Observation on 2nd TN floor through out the follow-up visit revealed staff providing diversional activities to wandering residents. No resident altercations were noted. The environment was calm with planned activities taking place. The facility will remain out of compliance at an "E" level until it provides an acceptable plan of correction to include continue monitoring to ensure the deficit practice does not recur and the facility's corrective measure would be reviewed and evaluated by the Quality Assurance Committee.	(F 520)	monthly flow records on 2nd Tennessee weekly for four weeks to ensure resident behaviors are properly documented. • The DON and or ADON will review Psychiatric consultation notes after each visit to ensure recommendations for medication adjustments are called to the Physician in a timely manner. • The DON/ ADON and or Quality Assurance Nurse will audit 100% of the Psychiatric notes and the medical record to ensure the physician is notified of recommendations for medication changes from Psychiatric services. Audits will be completed weekly for eight weeks and then biweekly for eight weeks and then PRN. *4. How the corrective actions will be monitored to ensure that the deficient practice will not recur; what quality assurance program will be put In place* • The Director of Nursing and/or Assistant Director of Nursing will report the findings of each audit to the Quality Assurance Committee (Medical Director, Administrator, Director of Nursing, and Assistant Director of Nursing, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Maintenance Director) monthly. • Quality Assurance Committee (Administrator, Director of Nursing, and Assistant Director of Nursing, Business Office Manager, Dietary Manager, Activities Director, Social Services Director, and Therapy Manager) will review findings and make recommendation to improve the process of communication related to residents maximum assistance level required by nursing staff for safe ambulation and transfers and determine when compliance has been reached.	5-11-12